



For office use only!

Date Received \_\_\_\_\_

I.D.# \_\_\_\_\_

Date Approved \_\_\_\_\_

## APPLICATION FOR MOBILITY IMPAIRED ELIGIBILITY

### SECTION 1

**TO BE COMPLETED BY APPLICANT ~ PLEASE TYPE OR PRINT**

**APPLICANTS WITH DISABILITIES:** Both sides of the application must be completed. **The Disability Certification on the reverse side must be completed by a physician to verify disability.**

Name: Mr  Ms  \_\_\_\_\_  
*First* *Initial* *Last*

Home Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

Home Address \_\_\_\_\_  
*Street or Box #* *City* *State* *Zip*

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

**EMERGENCY CONTACT** \_\_\_\_\_  
*Name* *Relationship* *Phone*

Personal Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
*Street or Box #* *City* *State* *Zip*

Assistive Devices Used (Please check all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> Cane                | <b>WHEELCHAIR TYPE:</b>                                     |
| <input type="checkbox"/> Walker              | <input type="checkbox"/> Standard Manual Conventional       |
| <input type="checkbox"/> Mobility/White Cane | <input type="checkbox"/> Electric Conventional              |
| <input type="checkbox"/> Crutches            | <input type="checkbox"/> Small Sized Scooter – Brand: _____ |
| <input type="checkbox"/> Prosthesis          | <input type="checkbox"/> Oversized Scooter – Brand: _____   |
| <input type="checkbox"/> Service Animal      | What service does animal provide? _____                     |

If using wheelchair, does your residence have a wheelchair ramp for multiple steps?  Yes  No  N/A  
 (NOTE: Driver cannot take a wheelchair up or down a step higher than 6" or more than one-step; ramps must be secure)

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| Do you require an attendant? -----  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have any condition of which we should be aware? -----                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have a valid driver's license? -----                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever filled out a <b>Mobility Impaired</b> application before? ----- | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

### RELEASE AND INDEMNIFICATION

I, \_\_\_\_\_, FOR AND IN CONSIDERATION OF THE CITY OF LAKE WORTH PROVIDING AND ALLOWING ME TO USE THE MOBILITY IMPAIRED TRANSPORTATION SYSTEM, AGREE TO RELEASE, DISCHARGE AND HOLD HARMLESS THE CITY OF LAKE WORTH, ITS OFFICERS, AGENTS, SERVANTS, EMPLOYEES, VOLUNTEERS, AND SPONSORS ASSISTING IN THE MOBILITY IMPAIRED PROGRAM FROM ANY AND ALL DAMAGES, CLAIMS OR LIABILITY OF ANY KIND WHATSOEVER, ARISING FROM PERSONAL INJURY OR PROPERTY DAMAGE SUSTAINED BY ME IN USING THE MOBILITY IMPAIRED TRANSPORTATION SYSTEM, WHETHER OR NOT CAUSED IN WHOLE OR IN PART BY THE ACTS, ERRORS OR OMISSIONS OF THE CITY OF LAKE WORTH OR ITS OFFICERS, AGENTS, SERVANTS, EMPLOYEES, VOLUNTEERS, SPONSORS OR INDEPENDENT CONTRACTORS.

I have read this Release and understand all of its terms and conditions. I execute it voluntarily and with full knowledge of its significance.

DATED THIS \_\_\_\_\_ DAY OF \_\_\_\_\_ 200\_\_\_\_\_.

\_\_\_\_\_  
Applicant's signature

\_\_\_\_\_  
Witness Signature

**VERIFICATION AND RELEASE OF INFORMATION**

I, \_\_\_\_\_, verify that the above information is true and correct to the best of my knowledge. I also authorize the personnel of the City of Lake Worth to obtain verification of any information given in this application, including, but not limited to proof of residency, and to obtain pertinent medical information necessary for clarification of ridership eligibility.

Applicant's signature \_\_\_\_\_

Date signed \_\_\_\_\_

**SECTION 2**

**DISABILITY CERTIFICATION**

• • • • • **This part must be completed by a physician for applicants with disabilities** • • • • •

**ATTENTION PHYSICIAN:**

An individual wishing to be certified with the City of Lake Worth for Mobility Impaired transportation must be transportation restricted by virtue of a physical/mental disability. The purpose of paratransit is **for those qualified persons whose only option for transportation is paratransit**. Eligibility will only be provided for those individuals in whom ADA paratransit eligibility standards have been met. All final decisions regarding eligibility are made by the Lake Worth Mobility Impaired administrative staff.

This applicant **is not** transportation restricted as described above.

1. What is the applicant's specific disability?

\_\_\_\_\_  
\_\_\_\_\_

2. If the applicant were of legal driving age, would he/she be able to safely operate a motor vehicle?  YES  NO

3. If no, what specific disability would prevent the applicant from doing so?

\_\_\_\_\_  
\_\_\_\_\_

4. Is the applicant's disability permanent?  YES  NO

5. If not, what is the approximate date of recovery?  Less than one month  Six months to one year  
 One to three months  One to two years  
 Three to six months  Over two years

6. Does the applicant require an attendant or supervision during transport?

YES Explain \_\_\_\_\_  
 NO

7. Does the patient have a history of, or currently have violent tendencies or will the patient present a behavioral problem during transport?

YES Explain \_\_\_\_\_  
 NO

Physician's Signature \_\_\_\_\_ Date completed \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_ Fax Number \_\_\_\_\_

City/State/Zip \_\_\_\_\_

**RETURN COMPLETED APPLICATION TO:** Lake Worth Shuttle Service  
3805 Adam Grubb  
Lake Worth, Texas 76135

**FOR OFFICE USE ONLY:** DATE CERTIFIED \_\_\_\_\_ I.D. NUMBER \_\_\_\_\_

Date and/or reason rejected: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_